

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044198

Facility Name: NORTHWOODS CARE CENTRE

Address: 2250 S. PEARL STREET BELVIDERE 61108
Number City Zip Code

County: BOONE

Telephone Number: (847) 544-0358 Fax # (847) 544-5006

IDPA ID Number: 36-3954529

Date of Initial License for Current Owners: 06/01/94

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust

IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☒ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid
Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____ (Date) _____
(Print Name and Title) BOB KAGDA PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number NORTHWOODS CARE CENTRE

0044198 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 04/09/02					
1	2	3	4		
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	116	42,732	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	116	42,732	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	10,976	4,208	3,883	19,067	8
9	SNF/PED					9
10	ICF	14,234	5,471	1,523	21,228	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,210	9,679	5,406	40,295	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.30%

D. How many bed-hold days during this year were paid by Public Aid?
128 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO X

I. On what date did you start providing long term care at this location?
Date started 06/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES X Date 06/01/94 NO

K. Was the facility certified for Medicare during the reporting year?
YES X NO If YES, enter number of beds certified 116 and days of care provided 2,701

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS
ACCRUAL X MODIFIED CASH* CASH*
Is your fiscal year identical to your tax year? YES X NO
Tax Year: 12/31/2002 Fiscal Year: 12/31/2002
* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	166,588	9,959	8,222	184,769		184,769	(2,152)	182,617			1
2	Food Purchase		138,227		138,227		138,227	(1,609)	136,618			2
3	Housekeeping	205,617	27,338		232,955		232,955	2,722	235,677			3
4	Laundry	42,540	12,769	1,800	57,109		57,109	433	57,542			4
5	Heat and Other Utilities			80,338	80,338		80,338		80,338			5
6	Maintenance	13,113	29,283	19,198	61,594		61,594	(225)	61,369			6
7	Other (specify):*			3,722	3,722		3,722		3,722			7
8	TOTAL General Services	427,858	217,576	113,280	758,714		758,714	(831)	757,883			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	1,403,960	65,295	42,495	1,511,750		1,511,750	(958)	1,510,792			10
10a	Therapy	20,342		10,235	30,577		30,577		30,577			10a
11	Activities	112,208	6,995	936	120,139		120,139	924	121,063			11
12	Social Services	48,272		7,750	56,022		56,022		56,022			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,584,782	72,290	64,416	1,721,488		1,721,488	(34)	1,721,454			16
	C. General Administration											
17	Administrative	108,563		437,993	546,556		546,556	(411,759)	134,797			17
18	Directors Fees											18
19	Professional Services			134,172	134,172		134,172	114,120	248,292			19
20	Dues, Fees, Subscriptions & Promotions			43,151	43,151		43,151	(31,627)	11,524			20
21	Clerical & General Office Expenses	100,826	24,626	29,876	155,328		155,328	83,696	239,024			21
22	Employee Benefits & Payroll Taxes			398,286	398,286		398,286		398,286			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,270	6,270		6,270	6,179	12,449			24
25	Other Admin. Staff Transportation			3,610	3,610		3,610		3,610			25
26	Insurance-Prop.Liab.Malpractice			93,021	93,021		93,021	95,642	188,663			26
27	Other (specify):*			14,646	14,646		14,646	(14,646)				27
28	TOTAL General Administration	209,389	24,626	1,161,025	1,395,040		1,395,040	(158,395)	1,236,645			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,222,029	314,492	1,338,721	3,875,242		3,875,242	(159,260)	3,715,982			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			52,556	52,556		52,556	65,699	118,255			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,796	38,796		38,796	126,837	165,633			32
33	Real Estate Taxes			65,770	65,770		65,770		65,770			33
34	Rent-Facility & Grounds			438,000	438,000		438,000	(426,468)	11,532			34
35	Rent-Equipment & Vehicles			8,359	8,359		8,359	5,319	13,678			35
36	Other (specify):* STORAGE			1,751	1,751		1,751		1,751			36
37	TOTAL Ownership			605,232	605,232		605,232	(228,613)	376,619			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		83,395	180,913	264,308		264,308		264,308			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,098	64,098		64,098		64,098			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		83,395	245,011	328,406		328,406		328,406			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,222,029	397,887	2,188,964	4,808,880		4,808,880	(387,873)	4,421,007			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(15,209)	30		9
10	Interest and Other Investment Income	(34,323)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,609)	2		13
14	Non-Care Related Interest	(4,473)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(130)	21		18
19	Entertainment		20		19
20	Contributions	(7,392)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,044)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,646)	27		24
25	Fund Raising, Advertising and Promotional	(25,193)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(155)	20		28
29	Other-Attach Schedule <u>SEE PAGE 5A</u>	7,028			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (97,146)		\$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(290,727)	PG 6, 6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (290,727)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (387,873)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Sch. V Line	
	Amount	Reference	
1	DEFERRED MAINTENANCE	\$ 1,356	6 1
2	VACATION ACCRUAL	(2,152)	1 2
3	VACATION ACCRUAL	2,722	3 3
4	VACATION ACCRUAL	433	4 4
5	VACATION ACCRUAL	(1,581)	6 5
6	VACATION ACCRUAL	(8,709)	10 6
7	VACATION ACCRUAL	924	11 7
8	VACATION ACCRUAL	14,395	17 8
9	VACATION ACCRUAL	(360)	21 9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	7,028	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number NORTHWOODS CARE CENTRE

0044198

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(2,152)	0	0	0	0	0	0	0	0	0	0	(2,152)	1
2	Food Purchase	(1,609)	0	0	0	0	0	0	0	0	0	0	(1,609)	2
3	Housekeeping	2,722	0	0	0	0	0	0	0	0	0	0	2,722	3
4	Laundry	433	0	0	0	0	0	0	0	0	0	0	433	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(225)	0	0	0	0	0	0	0	0	0	0	(225)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(831)	0	0	0	0	0	0	0	0	0	0	(831)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(8,709)	7,751	0	0	0	0	0	0	0	0	0	(958)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	924	0	0	0	0	0	0	0	0	0	0	924	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(7,785)	7,751	0	0	0	0	0	0	0	0	0	(34)	16
	C. General Administration													
17	Administrative	14,395	(426,154)	0	0	0	0	0	0	0	0	0	(411,759)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,044)	3,849	111,315	0	0	0	0	0	0	0	0	114,120	19
20	Fees, Subscriptions & Promotions	(32,740)	1,113	0	0	0	0	0	0	0	0	0	(31,627)	20
21	Clerical & General Office Expenses	(490)	83,786	400	0	0	0	0	0	0	0	0	83,696	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,179	0	0	0	0	0	0	0	0	0	6,179	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	3,599	92,043	0	0	0	0	0	0	0	0	95,642	26
27	Other (specify):*	(14,646)	0	0	0	0	0	0	0	0	0	0	(14,646)	27
28	TOTAL General Administration	(34,525)	(327,628)	203,758	0	0	0	0	0	0	0	0	(158,395)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(43,141)	(319,877)	203,758	0	0	0	0	0	0	0	0	(159,260)	29

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED NURSING HOMES		FIRST HEALTH CARE ASSOCIATES, LTD (DIVISION OF FHC ENTERPRISE, INC.)	MORTON GROVE	MANAGEMENT/ CONSULTANT
				NORTHWOODS HEALTHCARE CENTRE	MORTON GROVE	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	NURSING	\$	FHC ENTERPRISES INC.		\$ 7,751	\$ 7,751	1
2	V	17	ADMINISTRATIVE	437,993	MR. BELLOWS OWNS 57% OF THIS FACILITY		11,839	(426,154)	2
3	V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISES		3,849	3,849	3
4	V	20	DUES & SUBSCRIPTIONS		" "		1,113	1,113	4
5	V	21	CLERICAL		" "		83,786	83,786	5
6	V	24	TRAVEL		" "		6,179	6,179	6
7	V	26	INSURANCE		" "		3,599	3,599	7
8	V	30	DEPRECIATION		" "		4,207	4,207	8
9	V	34	RENT		" "		11,532	11,532	9
10	V	35	RENT - EQUIPMENT & VEH		" "		5,319	5,319	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 437,993			\$ 139,174	\$ * (298,819)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	\$ 438,000	NORTHWOODS HEALTHCARE CENTRE		\$	(438,000)	15
16	V	19	ACCOUNTING		" "		11,050	11,050	16
17	V	19	LEGAL		" "		265	265	17
18	V	19	OTHER PROFESSIONAL		" "		100,000	100,000	18
19	V	21	BANK CHARGES		" "		400	400	19
20	V	26	GENERAL INSURANCE		" "		82,133	82,133	20
21	V	26	MORTGAGE INSURANCE		" "		9,910	9,910	21
22	V	30	DEPRECIATION		" "		76,701	76,701	22
23	V	32	AMORTIZATION		" "		1,756	1,756	23
24	V	32	INTEREST - MORTGAGE		" "		148,103	148,103	24
25	V	32	INTEREST - OTHER		" "		15,774	15,774	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 438,000			\$ 446,092	\$ * 8,092	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								\$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	0.57	SEE ATTACHED	2	8.33	SALARY	11,838	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 11,838		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	GMAC		X	MORTGAGE		10/97	\$ 2,052,500	\$ 1,976,918		7.4500	\$ 148,103	1	
2	GMAC		X	LOAN COST			61,456	52,237			1,756	2	
3												3	
4												4	
5												5	
	Working Capital												
6	AMERICAN NATIONAL BK		X	LINE OF CREDIT	VARIES	12/00	975,000	241,700	DEMAND	PRIME+	30,495	6	
7	RELATED PARTIES	X		WORKING CAPITAL	VARIES	VARIES	173,297	482,878	DEMAND	PRIME+	15,774	7	
8	CRESTWOOD HEIGHTS	X		WORKING CAPITAL	VARIES	12/98	75,000		DEMAND	VARIES	3,828	8	
9	TOTAL Facility Related						\$ 3,337,253	\$ 2,753,733			\$ 199,956	9	
	B. Non-Facility Related*												
10	NORTHWOODS HEALTHCA	X		WORKING CAPITAL	DEMAND	VARIES	238,870			VARIES	4,473	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$ 238,870	\$			\$ 4,473	14	
15	TOTALS (line 9+line14)						\$ 3,576,123	\$ 2,753,733			\$ 204,429	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

<div>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</div>			
1. Real Estate Tax accrual used on 2001 report.		\$ 70,572	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 67,798	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (2,774)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 68,544	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 65,770	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

1997	66,995	8
1998	67,231	9
1999	67,637	10
2000	69,802	11
2001	67,798	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME NORTHWOODS CARE CENTRE COUNTY BOONE

FACILITY IDPH LICENSE NUMBER 0044198

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	07-01-151-003	NURSING HOME	\$ 67,798.06	\$ 67,798.06
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 67,798.06	\$ 67,798.06

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,500

B. General Construction Type: Exterior BRICK Frame Number of Stories 2/BASEMENT

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME		1981	\$ 50,050	1
2	754 BASIS ADJ.		1982	4,835	2
3	TOTALS			\$ 54,885	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1981		\$ 995,068	\$	30	\$ 33,169	\$ 33,169	\$ 729,718	4
5	754 BASIS ADJ		1992		111,968	3,555	31.5	3,555		37,325	5
6											6
7											7
8											8
	Improvement Type**										
9	RELATED PARTY - NORTHWOODS HEALTHCARE CENTRE										9
10	VARIOUS IMPROVEMENTS		1981		4,062		15			4,062	10
11	VARIOUS IMPROVEMENTS		1982		73,451		15			73,451	11
12	VARIOUS IMPROVEMENTS		1983		6,203		15			6,203	12
13	VARIOUS IMPROVEMENTS		1984		11,372		20	569	569	10,528	13
14	PAVING		1986		13,000	653	15		(653)	13,000	14
15	SHOWER		1986		4,151	205	25	166	(39)	2,739	15
16	ROOF		1988		38,383	1,219	31.5	1,219		17,726	16
17	DECORATING		1989		1,921	61	31.5	61		811	17
18	VARIOUS IMPROVEMENTS		1990		10,047	319	31.5	319		4,147	18
19	VARIOUS IMPROVEMENTS		1991		2,683	85	31.5	85		1,103	19
20	VARIOUS IMPROVEMENTS		1992		38,565	1,224	31.5	1,224		12,614	20
21	CARPET		1993		6,854	217	31.5	217		2,104	21
22	DRIVEWAY		1993		1,655	42	39	42		382	22
23	SPRINKMAN SONS		1993		1,525	39	39	39		322	23
24	VARIOUS IMPROVEMENTS		1994		3,137	209	15	209		1,776	24
25	VARIOUS IMPROVEMENTS		1994		170,951	6,216	27.5	6,216		45,391	25
26	DOORS		1995		5,029	129	39	129		1,013	26
27	LANDSCAPING		1996		51,185	1,861	27.5	1,861		11,764	27
28	ROOF REPAIR		1996		20,000	727	27.5	727		4,469	28
29	DRIVEWAY REPAIR		1996		4,775	174	27.5	174		1,038	29
30	CONCRETE RETAINING WALL FOR RAMP		1997		1,500	55	27.5	55		293	30
31	WALLCOVERING/HANDRAIL/FLOOR TILES		1997		46,256	1,682	27.5	1,682		8,855	31
32	DRYWALL/PAINTING/WALLPAPER INSTALLATION		1997		30,000	1,091	27.5	1,091		5,637	32
33	450000-GRAIN UNITS-WATER SOFTENER/COUNTER TOPS		1997		11,248	409	27.5	409		2,105	33
34	THREE WAY OVER BED RESIDENT LIGHTING		1998		12,600	458	27.5	458		1,953	34
35	GARBAGE DISPOSAL-KITCHEN REMODELING		1998		1,189	43	27.5	43		192	35
36	WINDOWS AND AUTO DOOR SYSTEM		1998		25,000	909	27.5	909		3,901	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	WALLCOVERINGS/CARPET/FLOOR TILES/GUARD RAILS	1998	\$ 68,941	\$ 2,507	27.5	\$ 2,507		\$ 11,842	37
38	TILES	1998	3,164	115	27.5	115		532	38
39	WOOD FLOORING	1998	4,705	171	27.5	171		762	39
40	COUNTER TOPS	1998	17,763	646	27.5	646		2,875	40
41	ELECTRICAL WIRING	1998	3,675	134	27.5	134		608	41
42	REMODELING - PAINTING/DRYWALL/WALLPAPER	1998	125,000	4,545	27.5	4,545		20,212	42
43	WALLCOVERING/TILES/HAND RAILS	1999	29,035	1,056	27.5	1,056		4,180	43
44	REMODELING-HALLS/REHAB/OFFICES/WASHROOMS	1999	100,000	3,636	27.5	3,636		14,090	44
45	TILES	1999	3,924	143	27.5	143		447	45
46	STAINLESS STEEL WALLS IN THE KITCHEN	1999	2,628	96	27.5	96		300	46
47	REMODELING - ARCHITECTURE	2000	4,000	145	27.5	145		429	47
48	BLACKTOP STRIPPING & SEALING	2000	4,050	270	15	270		675	48
49	AIRTHERM HEATERS	2000	34,363	1,249	27.5	1,249		2,863	49
50	SINGLESIDED SANDBLASTED URETHANE SIGNS	2001	2,540	169	15	169		254	50
51	DECORATIVE BRICK WALL AROUND PATIO	2001	2,070	75	27.5	75		128	51
52	FIRE ALARM PANEL	2001	2,388	87	27.5	87		141	52
53	SPEED BUMPS - PARKING LOT	2001	3,600	240	15	240		360	53
54	CARPETING - 1ST FLR CRDR, NURSING OFFICE, ENTRYWA	2002	12,079	2,416	5	2,416		2,416	54
55	LOOSE LAID BALLASTED RUBBER ROOF	2002	46,590	494	27.5	494		494	55
56	F&I.A.O SMITH WATER HEATER	2002	4,600	49	27.5	49		49	56
57									57
58									58
59									59
60									60
61			ADJ TO SL	33,046			(33,046)		61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,178,893	\$ 72,871		\$ 72,871		\$ 1,068,279	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 474,358	\$ 49,465	\$ 36,574	\$ (12,891)	3-15 YRS	\$ 167,374	71
72	Current Year Purchases	15,454	3,091	773	(2,318)	3-15 YRS	773	72
73	Fully Depreciated Assets							73
74	RELATED PARTIES	383,886	8,037	8,037		3-15 YRS	346,550	74
75	TOTALS	\$ 873,698	\$ 60,593	\$ 45,384	\$ (15,209)		\$ 514,697	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,107,476	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 133,464	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 118,255	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (15,209)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,582,976	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 4,522
- Description: SEE SCHEDULE ATTACHED
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	1999 DODGE RAM-VAN	\$ 295.13	\$ 3,837	17
18					18
19					19
20					20
21	TOTAL		\$ 295.13	\$ 3,837	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	\$
13.	/2004	\$
14.	/2005	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 87,561	\$		\$ 87,561	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,024			6,024	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			87,328			87,328	4
5	Physician Care	39-3	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				64,812		64,812	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, X-RAY, I.V. THERAPY Other (specify):	39-2					18,583		18,583	13
14	TOTAL			\$		\$ 180,913	\$ 83,395		\$ 264,308	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 346,160	\$ 469,631	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 87,861)	783,499	783,499	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,081	1,081	5
6	Prepaid Insurance	27,701	78,396	6
7	Other Prepaid Expenses	1,956	1,956	7
8	Accounts Receivable (owners or related parties)	1,610,487	1,732,559	8
9	Other(specify): ESCROW DEPOSITS		32,381	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,770,884	\$ 3,099,503	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,050	13
14	Buildings, at Historical Cost		995,068	14
15	Leasehold Improvements, at Historical Cost		1,071,858	15
16	Equipment, at Historical Cost	489,810	899,878	16
17	Accumulated Depreciation (book methods)	(365,959)	(1,988,190)	17
18	Deferred Charges		52,237	18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds		391,705	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 123,851	\$ 1,472,606	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,894,735	\$ 4,572,109	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 222,328	\$ 262,091	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	130,995	130,995	28
29	Short-Term Notes Payable	9,823	9,823	29
30	Accrued Salaries Payable	52,630	52,630	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	5,885	5,885	31
32	Accrued Real Estate Taxes(Sch.IX-B)		68,544	32
33	Accrued Interest Payable	2,783	2,783	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	79,393	79,393	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 503,837	\$ 612,144	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	281,857	281,857	39
40	Mortgage Payable		1,976,918	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 281,857	\$ 2,258,775	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 785,694	\$ 2,870,919	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,109,041	\$ 1,701,190	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,894,735	\$ 4,572,109	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,288,509	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,288,509	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	827,605	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) REPLACEMENT TAX	(7,073)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 820,532	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,109,041	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,514,893	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,514,893	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	813	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 813	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	120,779	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 120,779	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,636,485	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	758,714	31
32	Health Care	1,721,488	32
33	General Administration	1,395,040	33
	B. Capital Expense		
34	Ownership	605,232	34
	C. Ancillary Expense		
35	Special Cost Centers	264,308	35
36	Provider Participation Fee	64,098	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,808,880	40
41	Income before Income Taxes (line 30 minus line 40)**	827,605	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 827,605	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,051	2,191	\$ 63,638	\$ 29.05	1
2	Assistant Director of Nursing	2,015	2,178	45,009	20.67	2
3	Registered Nurses	14,723	16,563	382,862	23.12	3
4	Licensed Practical Nurses	13,121	14,092	244,209	17.33	4
5	Nurse Aides & Orderlies	52,413	55,719	607,460	10.90	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,935	2,009	20,342	10.13	8
9	Activity Director	1,938	2,166	27,946	12.90	9
10	Activity Assistants	12,114	12,786	84,262	6.59	10
11	Social Service Workers	3,397	3,796	48,272	12.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	6,014	6,593	79,163	12.01	14
15	Cook Helpers/Assistants	10,581	11,206	87,425	7.80	15
16	Dishwashers					16
17	Maintenance Workers	1,389	1,439	13,113	9.11	17
18	Housekeepers	22,673	24,122	205,617	8.52	18
19	Laundry	5,072	5,473	42,540	7.77	19
20	Administrator	1,946	2,566	108,563	42.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,138	6,590	100,826	15.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,940	4,513	60,782	13.47	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	161,460	174,002	\$ 2,222,029 *	\$ 12.77	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	177	\$ 6,188	1-3	35
36	Medical Director	48	3,000	9-3	36
37	Medical Records Consultant	12	774	10-3	37
38	Nurse Consultant	295	12,717	10-3	38
39	Pharmacist Consultant	192	1,440	10-3	39
40	Physical Therapy Consultant	80	4,222	10a-3	40
41	Occupational Therapy Consultant	93	6,013	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	19	936	11-3	44
45	Social Service Consultant	172	7,750	12-3	45
46	Other(specify) PSYCHO SOCIAL	126	14,598	10-3	46
47	UTILIZATION REVIEW	144	12,600	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,358	\$ 70,238		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
SUSAN MEAD	ADMIN		\$ 108,563	Workers' Compensation Insurance		\$ 46,035	IDPH License Fee	\$
			0	Unemployment Compensation Insurance		12,017	Advertising: Employee Recruitment	754
				FICA Taxes		167,105	Health Care Worker Background Check	960
				Employee Health Insurance		161,486	(Indicate # of checks performed)	
				Employee Meals		0	MARKETING/ADV/PROMO	25,348
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	7,392
				EMPLOYEE BENEFITS - OTHER		9,376	LICENSES & PERMITS	925
				EMPLOYEE PHYSICAL EXAMS		2,267	DUES & SUBSCRIPTIONS	7,772
				PENSION/PROFIT SHARING PLANS		0	MGMT CO ALLOCATION	1,113
TOTAL (agree to Schedule V, line 17, col. 1)				CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC	(7,392)
(List each licensed administrator separately.)				INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(0)
B. Administrative - Other				INSURANCE - EXECUTIVE LIFE VI 21		0	Non-allowable advertising	(25,193)
							Yellow page advertising	(155)
Description			Amount				TOTAL (agree to Sch. V, line 20, col. 8)	
FIRST HEALTH CARE	MANAGEMENT FEES		\$ 437,993			\$ 398,286	\$ 11,524	
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V, line 22, col.8)				
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
								0
							MANAGEMENT COMPANY ALLOC.	6,179
							Seminar Expense	
								6,270
							Entertainment Expense	()
SEE SCHEDULE ATTACHED			134,172				(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL	\$ 12,449
(If total legal fees exceed \$2500 attach copy of invoices.)								
			\$ 134,172					

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINT/DECORATING	06/2000	\$2,497	3	\$	\$416	\$832	\$832	\$417	\$	\$	\$	\$
2	PAINT/DECORATING	06/2001	1,571	3			262	524	524	261			
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$4,068		\$	\$416	\$1,094	\$1,356	\$941	\$261	\$	\$	\$

Facility Name & ID Number NORTHWOODS CARE CENTRE

0044198

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE - \$6624
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,869 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 64,098
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	6,188
	REPAIRS & MAINTENANCE	2,034
		0
		8,222
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,800
		0
		1,800
5	HEAT & OTHER UTILITIES	
	GAS HEAT	29,066
	ELECTRICITY	35,524
	WATER	14,938
	CABLE TV - LOBBY	810
		0
		80,338
6	MAINTENANCE	
	GROUNDS MAINTENANCE	850
	PAINTING & DECORATING	169
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	12,304
	ELEVATOR MAINTENANCE & REPAIR	4,764
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	660
	FIRE SERVICE	451
		0
		0
		0
		19,198
7	OTHER	
	SCAVENGER	3,722
	SECURITY SERVICE	0
		3,722
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	3,000
		3,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	366
	PSYCHO-SOCIAL CONSULTANT XVIII B 46-2	14,598
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	774
	PHARMACY CONSULTANT XVIII B 39-2	1,440
	UTILIZATION REVIEW FEES XVIII B 47-2	12,600
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	12,717
		0
		0
		42,495
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	4,222
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	6,013
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		10,235
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	936
		0
		936
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	7,750
		0
		7,750
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	0	0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 437,993	437,993
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 14,014	
	ADMINISTRATIVE CONSULTANTS	XIX C 0	
	PROFESSIONAL FEES	XIX C 120,158	
		0	134,172
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 25,193	
	EMPLOYEE WANT ADS	XIX F 754	
	CONTRIBUTIONS	VI 20 XIX F 2,000	
	DUES & SUBSCRIPTIONS	XIX F 7,772	
	LICENSES & PERMITS	XIX F 925	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 155	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 5,392	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 960	43,151
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,673	
	EQUIPMENT REPAIR & MAINTENANCE	1,945	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES	VI 18 130	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	720	
	TELEPHONE	25,408	
	MESSENGER SERVICE	0	
		0	29,876

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 167,105	
	UNEMPLOYMENT COMPENSATION	XIX D 12,017	
	WORKERS COMPENSATION INSURANC	XIX D 46,035	
	HOSPITALIZATION INSURANCE	XIX D 161,486	
	EMPLOYEE BENEFITS - OTHER	XIX D 9,376	
	EMPLOYEE PHYSICAL EXAMS	XIX D 2,267	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 0	
	CHICAGO HEAD TAX	XIX D 0	398,286
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	0	0
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 6,270	
	TRAVEL	XIX G 0	
		0	
		0	6,270
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	3,610	3,610
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	93,021	93,021
27	OTHER		
	BAD DEBTS	VI 24 14,646	
		0	14,646

GRAND TOTAL COLUMN 3 OTHER

1,338,721

NORTHWOODS CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	138,227	PATIENT MEALS	120885
LESS SALES TAX	(1,609)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	136,618	TOTAL MEALS/YEAR	120885
TOTAL PATIENT CENSUS	40,295	NET FOOD	136618
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	120885

TOTAL PATIENT MEALS	120885	COST PER MEAL	1.13
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

NORTHWOODS CARE CENTRE
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2002

INCOME PER F/S									5,474,907	
PER COST REPORT	NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
	1,721,488	398,286	378,609	57,109	322,996	996,754	64,098	605,232		2,222,029
ADJUSTMENTS:										
EQUIPMENT RENTAL/AUTO LEASE	859		1,685			5,815		(8,359)		
CABLE TV			(810)			810				
CONTRACT NURSING										
INTEREST INCOME							(120,779)			
NET VENDING COMMISSIONS										
EMPLOYEE PHYSICAL EXAMS		(2,267)				2,267				
INSURANCE - EXECUTIVE LIFE		0				0				
MANAGEMENT FEES						(437,993)		437,993		
O2 INCOME/RENT INSURANCE						(82,133)		82,133		
BAD DEBTS						(14,646)	14,646			
DISCOUNTS LOST							0			
ANCILLARIES	264,308							0		
SETTLEMENT INTEREST										
RECLASSSED SALARIES	0	0	0	0	0	0	0	0		
PROFIT SHARING	0	0	0	0	0	0	0	0		
PRIOR EXPENSES	0	0	0	0	0	0	(39,986)	0		
BENEFITS REBILLED	0	0	0	0	0	0	0	0		
RENT/INTEREST	0	0	0	0	0	0	0	0		
NURSE AID REIMB-STATE	0	0	0	0	0	0	(813)	0		
TOTAL COSTS	1,986,655	396,019	379,484	57,109	322,996	470,874	(82,834)	1,116,999	4,647,302	2,222,029
PER FINANCIAL STATEMENTS	1,986,655	396,019	379,484	57,109	322,996	470,874	(82,834)	1,116,999	827,605	2,222,029
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									827,605	

NORTHWOODS CARE CENTRE - COMPARISONS - 12/31/2002

	ref.	12/31/2002			12/31/2001			DIFF	12/31/2000		
CAPACITY DAYS		42,732			43800			(1,068)	43920		
CENSUS DAYS		40,295			39830			465	40073		
OCCUPANCY %		94.30%			90.94%				91.24%		
SALARIES											
TOTAL General Services	8-1	427,858	9.68%	10.62	502209	11.77%	12.61	(74,351)	444806	11.21%	11.10
Social Services	12-1	48,272	1.09%	1.20	49883	1.17%	1.25	(1,611)	44536	1.12%	1.11
TOTAL Health Care and Programs	16-1	1,584,782	35.85%	39.33	1541416	36.13%	38.70	43,366	1565685	39.46%	39.07
Clerical & General Office Expenses	21-1	100,826	2.28%	2.50	99421	2.33%	2.50	1,405	93491	2.36%	2.33
TOTAL General Administration	28-1	209,389	4.74%	5.20	198796	4.66%	4.99	10,593	194487	4.90%	4.85
TOTAL Operation Expense	29-1	2,222,029	50.26%	55.14	2242421	52.57%	56.30	(20,392)	2204978	55.57%	55.02
ADJUSTED TOTALS											
Food	2-8	136,618	3.09%	3.39	138810	3.25%	3.49	(2,192)	135338	3.41%	3.38
Heat and Other Utilities	5-8	80,338	1.82%	1.99	64503	1.51%	1.62	15,835	58237	1.47%	1.45
Maintenance	6-8	61,369	1.39%	1.52	67299	1.58%	1.69	(5,930)	86038	2.17%	2.15
TOTAL General Services	8-8	757,883	17.14%	18.81	825830	19.36%	20.73	(67,947)	738484	18.61%	18.43
Administrative	17-8	134,797	3.05%	3.35	108170	2.54%	2.72	26,627	109107	2.75%	2.72
Directors Fees	18-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
Professional Services	19-8	248,292	5.62%	6.16	256574	6.01%	6.44	(8,282)	212375	5.35%	5.30
Fees, Subscriptions, Promotions	20-8	11,524	0.26%	0.29	12489	0.29%	0.31	(965)	21507	0.54%	0.54
License Fee-IDPA	Pg21	0	0.00%	0.00	0	0.00%	0.00	0	200	0.01%	0.00
License Fee-Other	Pg21	925	0.02%	0.02	348	0.01%	0.01	577	7829	0.20%	0.20
Clerical & General Office Expenses	21-8	239,024	5.41%	5.93	238682	5.60%	5.99	342	227733	5.74%	5.68
Employee Benefits & Payroll Taxes	22-8	398,286	9.01%	9.88	355117	8.32%	8.92	43,169	328407	8.28%	8.20
Payroll Taxes	Pg21	179,122	4.05%	4.45	182836	4.29%	4.59	(3,714)	182982	4.61%	4.57
W/C Insurance	Pg21	46,035	1.04%	1.14	41463	0.97%	1.04	4,572	35360	0.89%	0.88
Health Insurance	Pg21	161,486	3.65%	4.01	108218	2.54%	2.72	53,268	86734	2.19%	2.16
Inservice Training & Education	23-8	0	0.00%	0.00	4226	0.10%	0.11	(4,226)	6475	0.16%	0.16
Travel and Seminar	24-8	12,449	0.28%	0.31	7664	0.18%	0.19	4,785	7491	0.19%	0.19
Other Admin. Staff Transportation	25-8	3,610	0.08%	0.09	4868	0.11%	0.12	(1,258)	3442	0.09%	0.09
Insurance-Prop.Liab.Malpractice	26-8	188,663	4.27%	4.68	99500	2.33%	2.50	89,163	67254	1.69%	1.68
Other (specify):*	27-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
TOTAL General Administration	28-8	1,236,645	27.97%	30.69	1087290	25.49%	27.30	149,355	983791	24.79%	24.55
TOTAL Operation Expense	29-8	3,715,982	84.05%	92.22	3618293	84.82%	90.84	97,689	3423595	86.28%	85.43
Real Estate Taxes	33-3	65,770	1.49%	1.63	71986	1.69%	1.81	(6,216)	68057	1.72%	1.70
Real Estate Legal	Pg10	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
GRAND TOTAL COST	45-8	4,421,007	100.00%	109.72	4265721	100.00%	107.10	155,286	3967900	100.00%	99.02
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		1710464.9	38.69%	42.45	1669016.4	39.13%	41.90	41,448	1489083.6	37.53%	37.16

NORTHWOODS CARE CENTRE - DIAGNOSTICS - 12/31/2002

This report DOES NOT REFLECT a 365-day year.

Page 3 Column 3 - Other is completely scheduled.

Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.

Total Adj on Page 4 Line 45-7 = Page 5 Line 37.

Deferred maint. adj. on Page 5A Line 1 consists of 1356 from Page 22 and 0 from Page 3 Line 6-3.

Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.

Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-165633

Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.

Real estate tax accrual on Page 10 Line 4 DOES NOT EQUAL Page 17 Line 32-1.

Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-80908

Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.

Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.

Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.

Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.

Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.

Page 17 Assets = Liabilities & Capital.

Net income on Page 18 Line 7-1 = Page 19 Line 43-2.

Administrative Salaries on Page 3 Line 17-1 = Page 21-A.

Management fees on Page 3 Line 17-3 = Page 21-B.

Professional fees on Page 3 Line 19-3 = Page 21-C.

Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.

Dues, etc. on Page 3 Line 20-8 = Page 21-F.

Travel expenses on Page 3 Line 24-8 = Page 21-G.